# Agenda Item 12

# Homefirst and Intermediate Care Update

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# Falkirk Integration Joint Board

**Home First and Intermediate Care Update**

**20 March 2020**

**For Noting**

## Executive Summary

1. This report gives an update on the Home First Test of Change and ongoing development of Summerford House Intermediate Care. It will demonstrate impact on the national unscheduled care targets during the period to date since its implementation.

2. The report highlights demand and activity on these services and impact on delayed discharges, length of stay and care home admissions.

3. The early evidence to date is showing a decreasing trend in delayed discharges, lost bed days and permanent admissions to care homes.

## Recommendations

The Integration Joint Board is asked to:

4. note the content of the report

5. note the impact of Home First on delayed discharge figures for Falkirk HSCP

6. note the impact on the numbers of people being admitted to care homes

7. continue to support the work within the HSCP Unscheduled Care Plan and NHSFV Winter Plan

## Background

8. At the meeting of November 2019, the IJB approved the progression of the HSCP Unscheduled Care Plan and the test of change for “Home First”. There was also approval from NHS Forth Valley for winter funding for increased beds within Summerford House Intermediate Care facility. This report provides the Board with an update on these two projects, and note of the impact on unscheduled care targets in particular Delayed Discharge figures.

9. The Falkirk HSCP Unscheduled Care Plan is based on the Scottish Governments 6 Essential Actions for Unscheduled Care and aims to provide a whole system approach to improve outcomes for people and support an improvement in performance against delivery targets. The Home First test of change and development of Intermediate Care were projects that underpin and support delivery of Essential Action 6: ensuring patients are optimally cared for in their own homes or a homely setting.

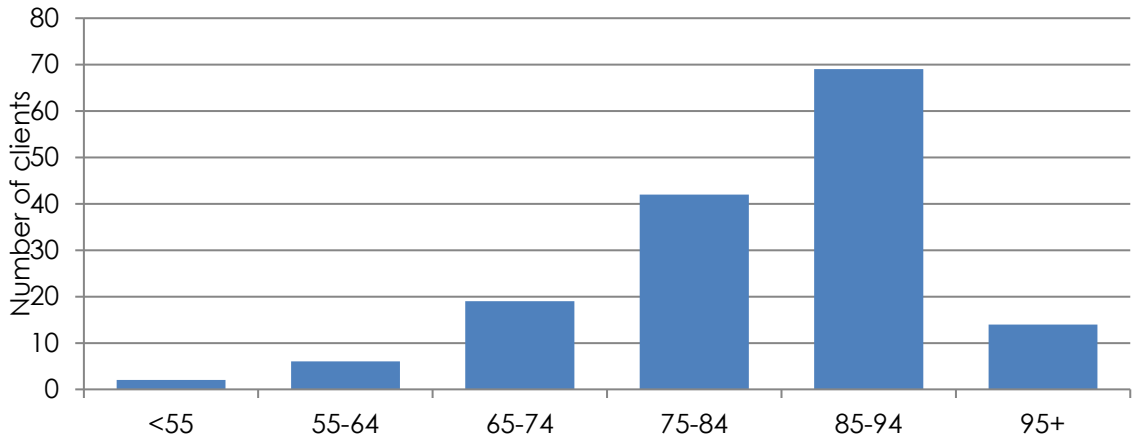
## Home First Summary

10. Home First is a multi-disciplinary team who liaise with the patient, their family and ward staff to support their timely discharge from hospital once medically well. The team will assess people's needs and make necessary arrangements for their discharge. The test of change started on 16 September 2019 in wards A11, A21 and B31. This was extended to the AU in February 2020 at the request of the Consultant Geriatrician. This section summarises the analysis completed using the available data on Home First.

11. As at 21 January 2020 there were a total of 174 patients supported by the Home First Team. The analysis in the report is based on approximately 130 patients, with the figures and charts representing the available information, which is dependent on data completeness. The completeness is improving as the availability of data to inform the evaluation of the test of change is required.

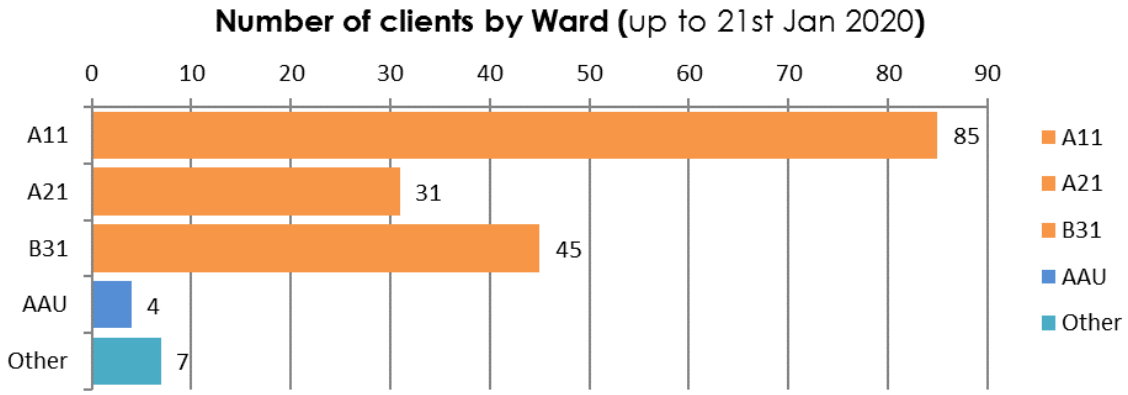
12. Figure 1 show the age category of people who were supported by the team. Of note is the majority of people are in the 85-94 years age range.

**Figure 1: Age Category - Home First Clients (**Up to 21.01.20**)**



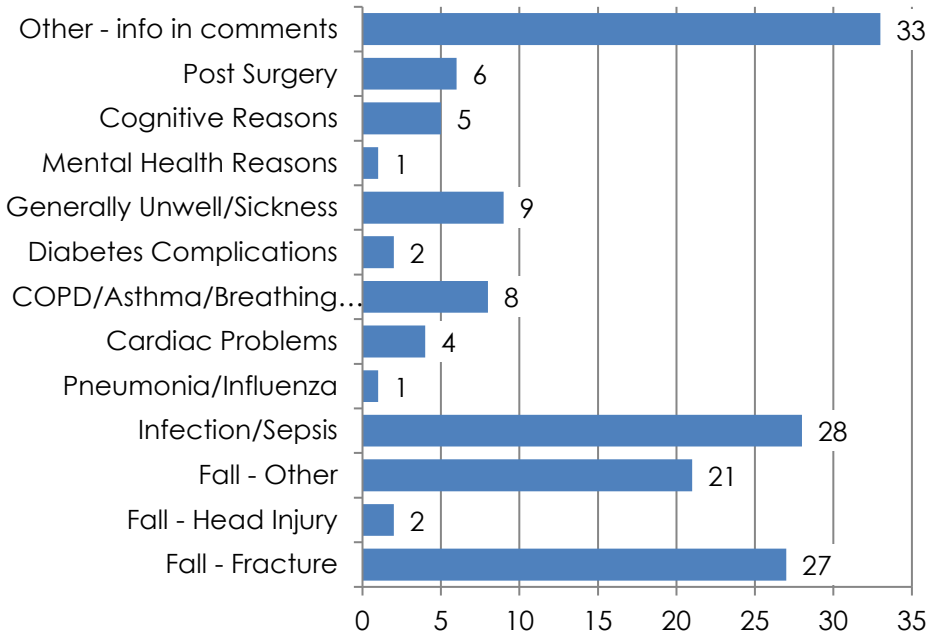

13. Figure 2 below provides information on the number of people who accessed the service by the 5 ward areas that are part of the test of change. Ward A11 had the highest number of people referred to the Home First Team (85), then wards B31 (45) and A21 (31).

Figure 1



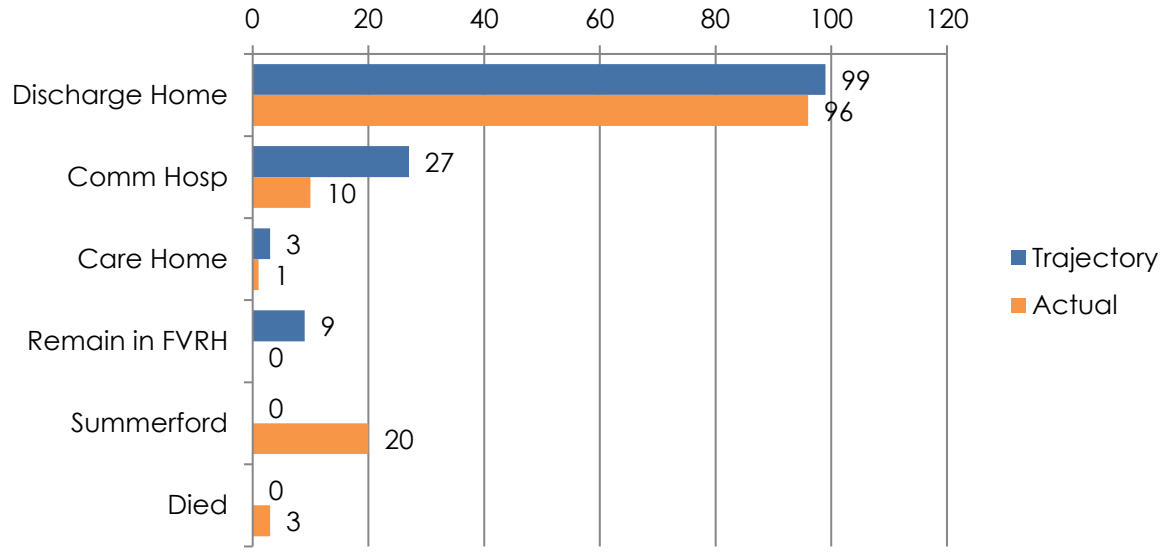

14. As part of the evaluation process, the reasons for admission to FVRH has been recorded. This is set out in Figure 3 below. This information will also be used to better understand the reasons people are admitted to hospital and to see if alternative community based provisions are in place or could be developed to respond to this need and prevent avoidable hospital admissions. This links to the work to review Partnership Funding projects and the Partnership Funding Investment Plan, with further information on this set out in the Partnership Funding report as a separate agenda item.

**Figure 3: Reason for Admission - Home First Clients (**Up to 21.01.20**)**




15. The evaluation process has also included information on people's discharge arrangements. On admission there is a proposed discharge trajectory set by ward staff, for example that a person is likely to go to the community hospital. The Home First team records the actual discharge arrangements, which could be different from the trajectory. This is set out in figure 4 below.

**Figure 4: Discharge Destination vs. Proposed Discharge Trajectory**
(Home First Clients up to 21.01.20)




16. The analysis notes:

- a high percentage of people were discharged home (74%)
- there was an increased use of Summerford intermediate care facility, which had previously not been identified as an option
- only 10 of the 27 people projected to go to community hospital actually transferred.

17. The evaluation process has also considered if there are any differences between Home First proposed discharge date and actual discharge dates. In many cases Home First suggested a discharge date that was before that of the estimated discharge date. The below measure looks at whether this earlier discharge date was generally achieved.

18. While there was a number of cases where the patient did not get discharged on the Home First proposed discharge date, there was also a number of cases where patients were discharged before the Home First proposed discharge date. The majority of patients went home on the Home First discharge date, and this is reflected in the average and median difference in number of days being zero days. Evidence that the Home First team are generally getting patients discharged on the day they planned.

19. **REACH Involvement**
REACH data has been included in the report, with information as at 19 December 2019. The REACH team have been involved with 32 Home First clients (either started or planned start date)

- 22 had a start date
- 3 planned
- 1 patient declined
- 4 had REACH input prior to admission
- 1 was in Summerford prior to admission

- 1 to be arranged
- Average time to REACH involvement following discharge – 8.4 days, with a median of 4 days.

20. **Rockwood Frailty Scale**

The Rockwood Frailty Scale has been introduced as the test of change has evolved. This is being used as a practical and efficient tool for assessing a person's frailty. It is used to assess patients into 9 classes from very fit (1) to terminally ill (9). Dependent on a person's assessed score there are suggested actions that should be taken by services to support people. This includes clinical assessment, risk assessment and care planning and ongoing referrals.

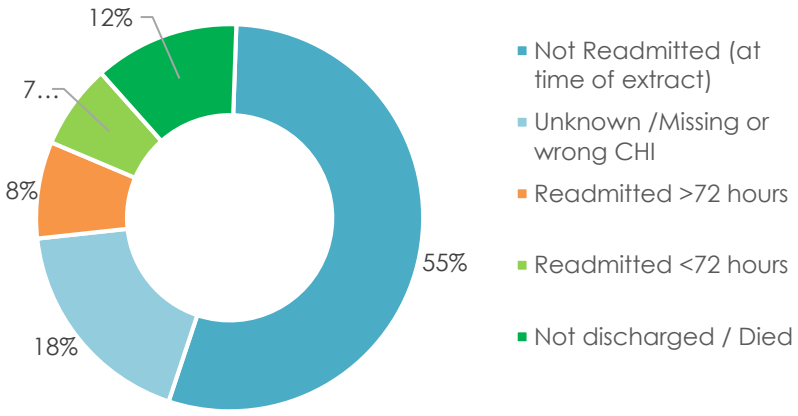
Since the introduction of the tool, 47 people had a Rockwood frailty score recorded in the acute setting and then at home. Of those people who had 2 scores recorded:

- 25 (53%) remained the same
- 18 (38%) improved by 1 or 2 points
- 4 (8%) got worse by 1 or 2 points.

21. **Readmission Rate**

A one off labour intensive exercise with support from the Discharge Hub was undertaken to monitor readmission rates of the cohort supported by Home First. The findings as at 4 December 2019 found that 15% of patients had been readmitted. It is important to note that this includes readmissions to any specialty and could be for unrelated reasons. This is set out in figure 5 below.

**Figure 2**




*Note – most recent patients included in this cohort are potentially not/very recently discharged and therefore unlikely to have been readmitted as yet.*

22. The NSS Discovery Tool was used to compare the readmission rate for Falkirk residents aged over 65, which was 14% in (2018/19). The Home First data collection has recently been adapted to include readmissions rates allowing this to be monitored on an ongoing basis.

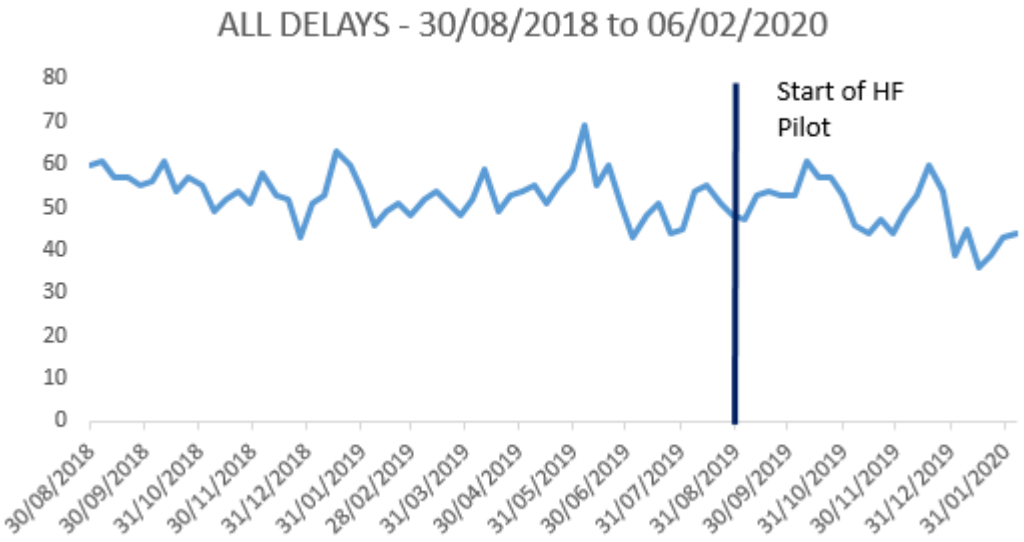
23. **Intermediate Care – Summerford House**
Winter funding has been made available to the HSCP to increase the number of beds from 19 to 26 within Summerford House to provide bed based intermediate care. Intermediate Care focusses on reablement programmes to achieve the potential to return home. The current average length of stay in Summerford House is 21.5 days.

24. This has supported discharges from FVRH and Falkirk Community Hospital to help maintain flow within acute settings. It has also provided an alternative reablement environment to create capacity in community hospital.

25. **Home First & Delayed Discharges**
One of the aims of the Home First Pilot is that partners will start to see an impact on delayed discharges. At the same time, it should be recognised that it is not the sole purpose of the pilot and in most cases the service aims to start supporting a patient before they are delayed in their discharge.

26. Delayed discharge performance is complex and impacted upon by multiple factors, Figure 6 below shows the variance in the system on a weekly basis. The chart shows the number of Falkirk residents identified as a delayed discharge at the weekly census point for all delayed discharge reasons from a year before the start of the Home First pilot to the most recently available data.

Figure 6




27. Figure 7 below reports the packages of care (POC) delays and care home delays at the weekly census point. The first 13 weeks of the pilot demonstrated a sustained period of low delays for packages of care. However, greater variation was found over the December and January period.

28. Care home delays are traditionally one of the largest contributors to delayed discharge in Falkirk. They also tend to be complex and lengthy delays. Since the end of October 2019 there been a decreasing trend, with some variation, of care home delays. In January 2020 for three weeks in succession there were 6 care home delays at the census point which is the lowest number of care home delays recorded at the census point in over 3 years.

Figure 7

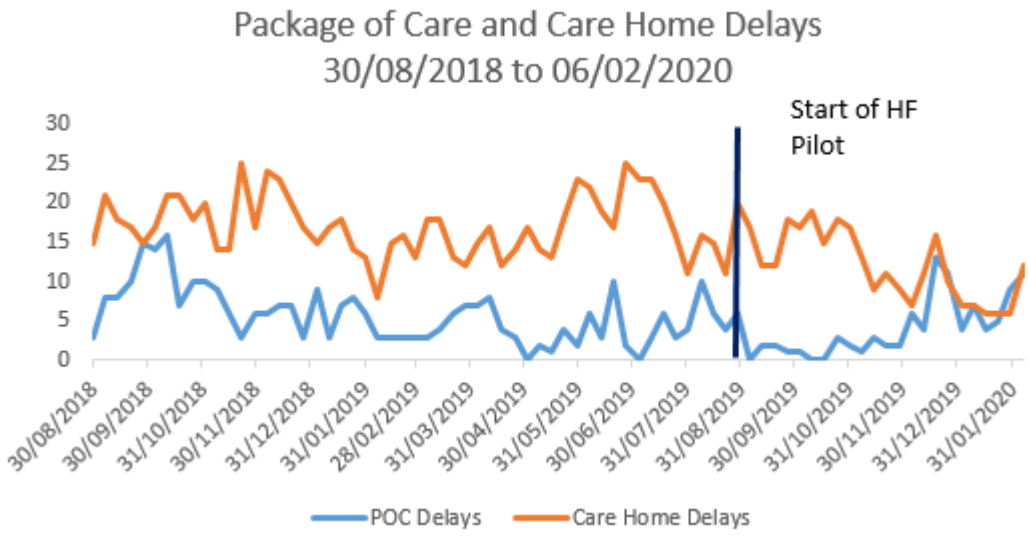
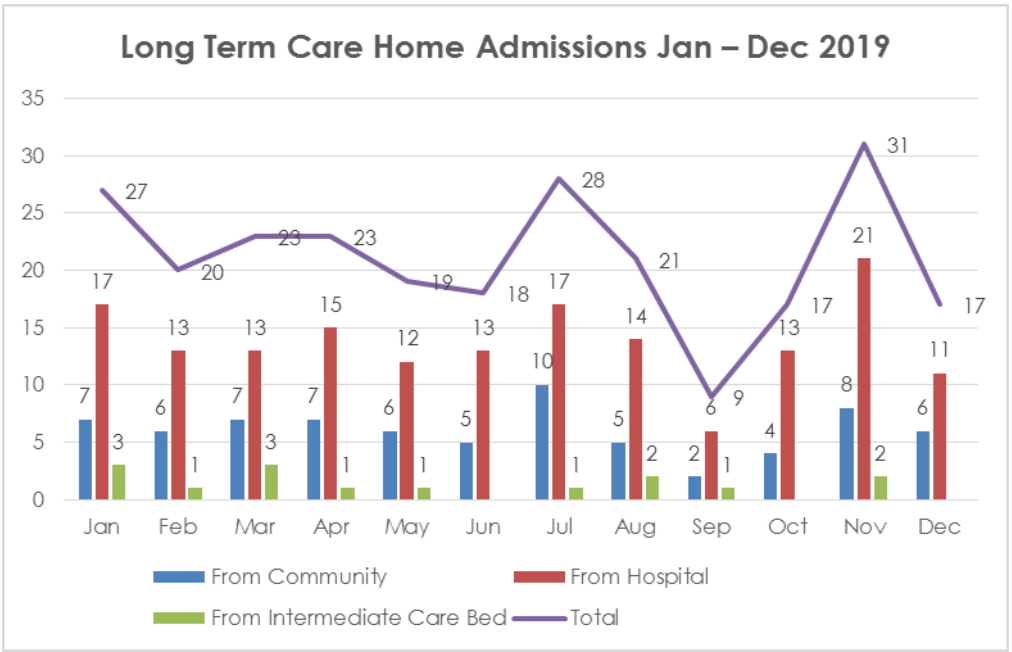
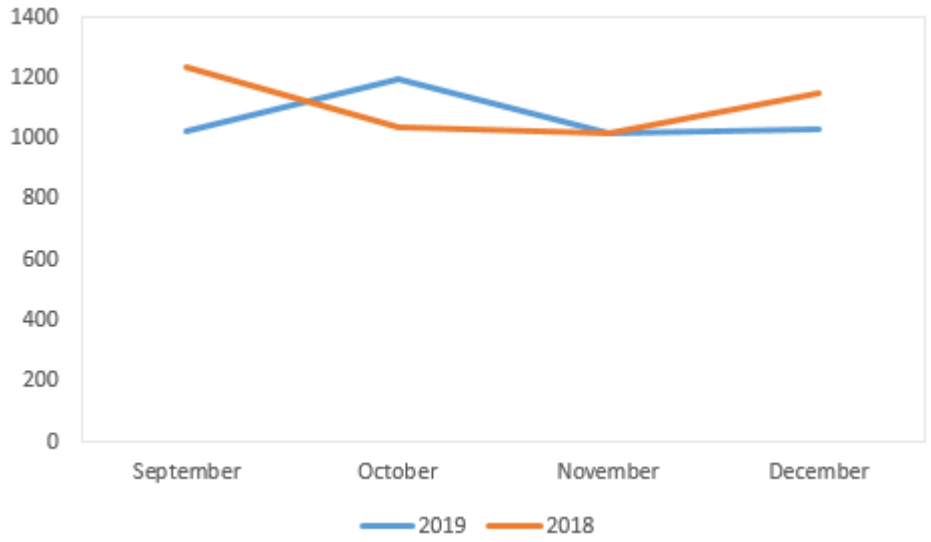



**Figure 8**: Trend data for care home admissions 2019



29. Figure 9 below, illustrates the bed days occupied by delayed discharges for health and social care reasons for the period of the pilot to date and for the equivalent period for the year below. The graph shows that there have been similar bed days lost between the pilot period and the equivalent period before with a marginal reduction of 171 days across the 4 months of the Home First pilot period.

**Figure 9: Bed Days Occupied by Delayed Discharges for Health & Social Care Reasons – September to December 2018 vs September to December 2019**




30. As stated earlier delayed discharge performance is complex and effected by many factors. It is important to consider this when interpreting the data in relation to Home First. While there is some evidence of improvement and variation across different measures multiple factors will be contributing to this.

## Conclusions

31. From the presenting data and information, there is evidence to support the application of the Home First approach to discharges in a whole system approach to unscheduled care. This approach should be applied across all wards in FVRH, Falkirk Community Hospital and Bo'ness Community Hospital.

32. There is also scope to apply this to the front door of the hospital and frailty clinics, to support turn around and prevent unnecessary acute admissions with additional funding investment to resource the team.

33. There is also evidence to support the bedded intermediate care model, to support step down from an acute setting and a higher level of reablement prior to discharge home.

### Resource Implications
The HSCP are currently reviewing the team structures to support the home first, rapid response and reablement approach to whole system working. This is being done alongside work to review assessment and care management practice in the community. This work will support the management of demand against capacity for delivery of community care services including home care.

### Impact on IJB Outcomes and Priorities
This Home First ethos and practice, in addition to a reablement model in intermediate care are models in action to support the Falkirk HSCP's integration outcomes for its communities.

### Legal & Risk Implications
There are no implications arising from the report.

### Consultation
None required at present.

### Equalities Assessment
This is not required for the report. Any service redesign will consider equality impact assessment requirements.

## Report Author

Approved for submission by: Patricia Cassidy, Chief Officer

**Author of report – Lorraine Paterson, Head of Integration**

## List of Background Papers

The papers that may be referred to within the report or previous papers on the same or related subjects.